UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

IN RE BEXTRA AND CELEBREX MARKETING, SALES PRACTICES AND PRODUCTS LIABILITY LITIGATION	Master Docket No. M:05-CV-01699-CRB MDL No. 1699
THIS RELATES TO: MDL Case No. _____	Plaintiff: _____ (name)

Name: _____

Date of Birth: _____

Social Security Number: _____

HIPAA COMPLIANT AUTHORIZATION FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

(Psychological Injury Claimed)

This authorization does NOT authorize the release of records of abortion. DO NOT RELEASE such records.

Person/Entity from Whom Records are Requested: _____
Provider Name ("Provider")

_____
Address City, State and Zip Code

Patient: _____
Patient Name

_____
Address City, State and Zip Code

Information Authorized To Be Disclosed: I authorize the Provider to furnish copies of my entire medical record and all of my individually identifiable health

information, to include but not be limited to: x-ray reports, CT scan reports, echocardiographic recordings, radiographic films, blood tests, MRI scans, MRA films, EEGs, EKGs, sonograms, arteriogram, pathology specimens, discharge summaries, photographs, videos, DVDs, emails, or other electronically stored information, data, or images, surgery consent forms, admission and discharge records, operation records, doctor and nurses notes, progress notes, prescriptions, medical bills, medical reports and records, invoices, histories, diagnoses, narratives, correspondence, memoranda, and billing information, pharmacy/prescription records including NDC numbers and drug information handouts/monographs. If the Provider is in possession of records from any other source, I authorize release of those records under this authorization.

This authorization includes records for treatment of psychological, psychiatric and emotional problems. It also includes, to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

This authorization does NOT authorize the release of records of abortion. DO NOT RELEASE such records.

Person to Whom Records are to be Disclosed ("Recipient"): I authorize disclosure of the above specified information to the defendant in the litigation captioned *In re Bextra and Celebrex Marketing, Sales Practices and Products Liability Litigation*, Master Docket No. M:05-CV-01699-CRB, MDL No. 1699, in which I am a plaintiff, and its authorized agent as set forth below:

Medical Research Consultants – Attn: RECORD RETRIEVAL
Name of Recipient or Recipient's Agent

Agent for Service of Record on Behalf of Defendant Pfizer Inc.
Relationship to Recipient

6330 West Loop South, Suite 105 Bellaire, TX 77401
Address City, State and Zip Code

I further authorize disclosure to any other counsel of record for Pfizer Inc. in the above captioned litigation that may be named in the future. The Recipient has agreed to pay reasonable charges incurred by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting disclosure of these records in connection with the above-referenced litigation in which I am a plaintiff.

Acknowledgements:

I understand that once information covered by this authorization has been disclosed, redisclosure of that information by the Recipient is possible, and the information may no longer be protected by federal or state law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for (please initial):

_____ Drug or alcohol abuse

_____ Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other sexually transmitted diseases

_____ Sickle Cell Anemia

_____ Tuberculosis

_____ Genetic testing and counseling

I understand that my signing of this authorization is voluntary. Refusing to sign or revoking this authorization will not affect my health care treatment, enrollment in my health plan, or eligibility for payment and benefits under my health plan.

I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

Term: This authorization shall be valid through December 31, 2010 or the conclusion of my case, whichever occurs first. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Recipient any additional records created or obtained by the Provider after the date hereof.

Revocation: I understand that I may revoke this authorization at any time by writing to the Provider at the Provider's above address, but my revocation will not apply to information that has already been released before the Provider receives notice of any revocation. Cancellation, revocation, or modification will only be valid once the Provider receives written notification of such cancellation, revocation or modification. A copy of said notification shall also be sent to Stuart M. Gordon at Gordon & Rees. I also understand that provision of this signed authorization is required by Order of the Court in the litigation to which this authorization pertains, and that such revocation, without good cause, may consequently lead to sanctions.

Copies: Any photostatic copy of this document shall have the same authority as the original, and may be substituted in its place.

Date: _____ _____

Signature of Patient or Legal/Personal Representative

_____

Description of Representative's Authority to Act for Patient, if Applicable

FOR MRC USE ONLY –

Plaintiff's Lawyer(s) to Receive Notices of Receipt of Requests and Records:

Lawyer's Name(s): _____
Firm Name: _____
Lawyer's Email(s): _____
(Required) _____
_____